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PILLARS FOR PROGRESS ON THE RIGHT TO HEALTH: HARNESSING THE POTENTIAL OF HUMAN RIGHTS THROUGH A FRAMEWORK CONVENTION ON GLOBAL HEALTH

Eric A. Friedman and Lawrence O. Gostin

ABSTRACT

Ever more constitutions incorporate the right to health, courts continue to expand their right to health jurisprudence, and communities and civil society increasingly turn to the right to health in their advocacy. Yet the right remains far from being realized. Even with steady progress on numerous fronts of global health, vast inequities at the global and national levels persist, and are responsible for millions of deaths annually. We propose a four-part approach to accelerating progress towards fulfilling the right to health: 1) national legal and policy reform, incorporating right to health obligations and principles including equity, participation, and accountability in designing, implementing, and monitoring the health sector, as well as an all-of-government approach in advancing the public's health; 2) litigation, using creative legal strategies, enhanced training, and promotion of progressive judgments to increase courts' effectiveness in advancing the right to health; 3) civil society and community engagement, empowering communities to understand and claim this right and building the capacity of right to health organizations; and 4) innovative global governance for health, strengthening World Health Organization leadership on health and human rights, further clarifying the international right to health, ensuring sustained and scalable development assistance, and conforming other international legal regimes (e.g., trade, intellectual property, and finance) to health and human rights norms. We offer specific steps to advance each of these areas, including how a new global health treaty, a Framework Convention on Global Health, could help construct these four pillars.

INTRODUCTION

Each year, nearly 20 million people die—one in three global deaths—as a result of inequities between richer countries and the rest of the world and within low- and mid-income countries.¹ A child entering the world today in sub-Saharan Africa has a life expectancy more than a quarter century shorter than a child born in a wealthy country.² Women in the poorest quintile in Southern Asia are five times less likely to be attended by a skilled birth attendant than those in the wealthiest quintile.³ The comparable disparity between wealthier and poorer women in West and Central Africa is three-and-a-half times.⁴

These persisting inequalities live alongside a far more promising reality for global health. The past several decades have demonstrated that great progress is possible. Child mortality has fallen from 16 million in 1970 to 7.6 million in 2010.⁵ Maternal mortality has fallen from more than 500,000 maternal deaths every year to approximately 287,000 in 2010.⁶ The number of people with HIV/AIDS in sub-Saharan Africa on anti-retroviral medication increased from about 50,000 in 2000 to 5,064,000 by

the end of 2010.⁷ In Brazil, the inequalities between rich and poor women in their access to skilled birth attendants that mark so much of the world have been close to eliminated, with near universal coverage of skilled birth attendants.⁸

How can the international community bring the first tragic reality in line with the second, far more hopeful, reality? We believe the right to the highest attainable standard of physical and mental health can be a force to enable even the world's poorest people to benefit from the immense health improvements that we know to be possible—interventions that are proven and affordable.⁹ Increasingly, civil society and communities, courts and constitutional assemblies, are turning to the right to health as tool for developing a more just society. The six new national constitutions adopted in 2010 all codified the right to health.¹⁰ Court decisions based on the right to health are burgeoning. Social movements are turning to the right to health in their advocacy. The UN General Assembly has recognized the right to clean drinking water and sanitation—two of the underlying determinants of health.¹¹ The days when a government could argue that the right to health was simply aspirational and unenforceable seem distant.

Yet none of this progress has fundamentally changed the gaping inequalities between rich and poor and other marginalized and disadvantaged populations. How, then, is it possible to accelerate and consolidate the progress already made in improving health and closing health inequalities? Here we propose a four-part approach to accelerating progress towards fulfilling the right to health and reducing both global and domestic health inequities: 1) incorporating right-to-health obligations and principles into national laws and policies; 2) using creative strategies to increase the impact of national right-to-health litigation; 3) empowering communities to claim their right to health and building civil society's health and human rights advocacy capacity, and; 4) bringing the right to health to the center of global governance for health.

These facets will be mutually reinforcing. Empowered communities are more likely to take advantage of the potential for litigation to enforce national policies, while global governance structures could bolster support for public right-to-health education and establish policy standards.

A global health agreement—a Framework Convention on Global Health (FCGH)—could help construct these pillars.¹² A civil society-led international coalition, the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI), is steering a process to develop just such a treaty.¹³ The FCGH would aim to dramatically reduce health inequities and establish a post-Millennium Development Goals (MDGs) global health agenda rooted in the right to health, placing such right-to-health principles as equality, accountability, and empowerment—as well as clearly defined responsibilities—at the center of this agenda in ways that the MDGs did not. The treaty would further elaborate on the right to health, from clarifying and codifying the interpretation of this right by the Committee on Economic, Social, and Cultural Rights to setting clearer standards for the progressive realization and maximum of available resource obligations in the International Covenant on Economic, Social, and Cultural Rights. The FCGH would also establish norms, targets, mechanisms, processes, and specific obligations that would give further life to central principles, such as accountability, participation, non-discrimination, and equality, while incorporating approaches to ensure proper prioritization of health, and of the right to health in other sectors such as trade, investment, and the environment.

In the spirit of the principles that comprise the right to health itself, JALI intends the FCGH to be developed through an inclusive and consultative process that amplifies the voices of the people who suffer most from national and global health inequities. To help inform this dialogue, we explore this four-pronged framework to better realize the right to health and offer ideas on how an FCGH could advance each pillar.

INCORPORATING THE RIGHT TO HEALTH INTO NATIONAL LAW AND POLICY

National legal and policy reform should begin at the top, incorporating the right to health into the constitution. A constitutional right to health does not guarantee that the government will respect the right or that health outcomes will improve. However, it does provide a foundation for action, whether catalyzing legal and policy reforms or unlocking the potential for litigation to enforce this right where other routes (e.g., constitutional right to life, judicially enforceable international treaties, and legislation) are unavailable or insufficient.

Incorporating the right to health does not require wholesale constitutional reform, but rather can be incorporated as a separate constitutional amendment. Civil society campaigns could valuably direct national attention to this and other socioeconomic rights. Right-to-health provisions in other constitutions and information on their implementation should be readily available to assist advocates in determining the specific amendment language that they seek, and to build public and political understanding of what such a right would entail and its possible benefits. This is not presently the case.¹⁴

The World Health Organization (WHO), civil society, and academics could establish an online, dynamic, regularly updated list of all right-to-health constitutional provisions, and analysis of how these provisions have been interpreted and implemented. This could help expand the scope of the possible, as advocates see how constitutions like Kenya's incorporate rights to such fundamental human needs as sufficient food, water, sanitation, and adequate housing; how Brazil's constitution demands universal and equal access to health care and establishes a formula for minimum government health spending on public health activities and services; and how Bolivia's constitution guarantees participation of the population in the decision-making processes of the public health system.¹⁵

An FCGH could aid in these efforts, requiring that states make the right to health justiciable. In countries that already have the right to health in their constitutions, or in which the FCGH (or other treaties with the right to health to which they are party) is self-executing, the right to health would already be justiciable. Elsewhere, states might meet this obligation by passing legislation to domesticate the FCGH—or by enacting a constitutional amendment. This requirement would be comparable to provisions in the International Covenant on Civil and Political Rights obliging parties to develop the possibility of a judicial remedy, and to enforce that remedy for violations of treaty rights.¹⁶

Laws, regulations, and policies should incorporate principles of equity, participation, and accountability. Comprehensive approaches to health equity will

include non-discrimination legislation with effective sanctions, disaggregated health data and equity targets for poor and marginalized populations with accompanying strategies and time-bound benchmarks; and equitably distributed funding, health workers, and facilities. Legislation should require that all processes involving health-related decision making engage civil society and community members with standards to ensure that members of marginalized groups are able to fully participate.

Countries could commit through an FCGH to disaggregate health data by sex, rural or urban residence, and other dimensions, and through periodic surveys or other means assess health disparities that may be harming other populations. Health information systems could also be strengthened to capture how health funds are disbursed, both to monitor funding across regions (for example, whether indigenous areas are receiving disproportionately few funds) and to compare actual disbursements with committed funds, which could reveal corruption or other malfeasance. Perhaps within prescribed minimum benchmarks, equity-related targets could be among the targets in an FCGH, or those that the FCGH commits countries to set for themselves. The treaty could commit countries to a multi-faceted approach—addressing a patient bill of rights, pre- and in-service health worker training, structural measures (e.g., infection control and prevention), and effective complaint mechanisms—to reduce health sector stigma and discrimination. It could also establish guidelines for inclusive health decision making at sub-national, national, and international levels.

The FCGH could encourage wealthier countries to fund these measures. It might even establish a right-to-health capacity-building fund to which FCGH parties would contribute, possibly under an agreed formula to ensure that the fund contains at least minimum necessary resources for the full gamut of right to health related capacity-building activities under the FCGH. This could represent a distinct channel of funding within a larger global health funding mechanism.

Accountability requires that people have the opportunity to understand and question government policies and actions, get answers, challenge

responses, and obtain redress for rights violations. Transparency is critical for accountability: India's Right to Information Act of 2005 has proven one of civil society's most important recent new tools to advance human rights.¹⁷ Transparency will also help tackle corruption and protect rights, as will powerful, independent anti-corruption bodies.

Improving domestic accountability would be one of the chief goals of an FCGH. It could require countries to develop, implement, monitor and evaluate, and report back on a strategy to improve health accountability at the community level, such as through functioning village health committees, community scorecards, or community monitoring. The treaty could require and support capacity-building for maternal, newborn, and child mortality audits.¹⁸ It could ensure and provide standards for implementing the right to information, akin to India's law, at the least for health and related sectors. The treaty could also prescribe a multitude of measures to improve transparency in health and related sectors, such as publishing (including on the Internet) all health plans and strategies, including in minority languages; discouraging corruption by requiring health ministry officials to publish their private assets online; in general, using open, transparent, competitive bidding processes for contracts of the ministry of health (and of related ministries, such as water); and informing communities of health funds that they are supposed to receive for local health services.

A right-to-health approach requires adequate funding. Laws could establish minimum funding levels for health, as in Brazil. Governments should use all policy levers to increase funding for health and its determinants. One analysis identified five such levers: 1) the proportion of government expenditure that is health-related; 2) overall government revenue; 3) official development assistance; 4) borrowing (deficit financing); and 5) monetary policy and financial regulation.¹⁹ We would add a sixth: ensuring the efficient use of resources. The WHO conservatively estimates that fully 20-40% of the world's health "spending is consumed in ways that do little to improve people's health."²⁰ Changed incentive structures for health providers, strategic health sector purchasing, reduced fragmentation of health financing, and greater focus on health equity are just some of the ways to improve efficiency and meaningfully channel available resources to health.²¹

Countries should explore innovative approaches to raising revenue, such as taxing unhealthy foods and imposing special levies on large, profitable companies.²² An FCGH might commit countries to implement a minimum number of such approaches, which the treaty could delineate. Beyond establishing domestic and international assistance funding benchmarks, the treaty could state circumstances under which countries are obliged to seek international assistance, owing to domestic resources that are inadequate to meeting their populations' right to health.

The rights approach to health also demands respect for the central, but often violated, public health principles of developing policies based on evidence and adopting an all-of-government approach in advancing the public's health. Countries could develop institutions specifically charged with advocating for and coordinating government efforts to incorporate health and human rights into all policies. For instance, Uganda established a right-to-health desk in the health ministry, charged with building capacity among health professionals on the right to health, mainstreaming the right to health in the health sector, and advocating for incorporating right-to-health-based policies in other sectors.²³ Parliamentary committees responsible for health or human rights oversight should hold hearings on health and human rights. An FCGH could commit governments to establishing a right-to-health office to coordinate a health—and right to health—in all policies approach, as well as to educate the public on their right to health, promote health worker education on human rights, motivate support for the right to health within the government, and provide or ensure legal assistance for people when their right to health has been violated.²⁴ The treaty could require a comprehensive public health strategy encompassing social determinants of health, and its funding benchmarks could extend beyond health care to address underlying determinants of health.

Codifying the right to health and developing accountability mechanisms will transform sound health policy into enforceable legal requirements. Policies on particular health issues must also integrate human rights standards, such as funding clean needle exchange to reduce HIV transmission among drug users, domesticating the Convention on the Rights of People with Disabilities, and conducting right-to-health assessments.

Health and right-to-health assessments are seeing growing use across a great variety of contexts, from assessing health and health-related policies—such as a gender action plan in Pakistan and maternal health policy in Bangladesh—to projects that might at first glance seem to have little relation to health, such as replacing a bridge.²⁵ They can lead to critical recommendations. The maternal health policy assessment in Bangladesh, using the Health Rights of Women Impact Assessment Instrument, led to recommendations to strengthen sub-district health advisory committees and have health facilities accommodate social and religious practices. The health impact assessment of the bridge included recommendations to minimize risk of injury to pedestrians and bicyclists and to reduce air pollution and other negative health effects of construction.

An FCGH could set minimum standards on when countries should conduct right-to-health assessments of policies outside the health sector that could impact health, and require a right-to-health assessment of the health system itself as a foundation for revising a national health strategy, as well as to assess the impact of health policy changes on the right to health. The treaty could require that countries follow the policy that would most positively affect health or the right to health or, if they do not, to publicly justify the chosen approach and establish processes for affected populations or civil society organizations to challenge the decisions. Beyond right-to-health assessments, an FCGH might even direct countries to implement specific policies, such as permitting syringe exchange.

Beyond the FCGH itself, how to give life to this ambitious agenda? As a foundation, government officials need to understand the right to health. Civil society, academics, and international civil servants all have a role in educating government officials, including parliamentarians, on health and human rights. To enable health in all policies, this education should cover all officials, not only those with an explicit health mandate.

Building right-to-health capacity

A right-to-health capacity-building fund in an FCGH could support these efforts. WHO could train and designate a human rights point person in each of its country offices. Such point people will need to closely collaborate with partners to ensure that their impact extends beyond the health ministry.

Policymakers will need to be convinced of the link between the right to health and improved health outcomes. For example, they need to be convinced that public participation in health decision making and community-based accountability structures indeed impacts health services and health outcomes. More research is needed, but evidence is emerging.²⁶ Organizations supporting these types of mechanisms should carefully monitor and evaluate their impact, and explore possibilities for linking with researchers to develop rigorous evidence of success. Foundations should fund this research and the community monitoring efforts themselves. The health impacts of these empowering community mechanisms can be every bit as great as many of the most powerful biological medicines.

Whether established through an FCGH or an independent effort, a global database collecting information on these initiatives could both help countries and communities design the most effective mechanisms and convince policymakers of their importance. If linked to the treaty, it could encourage states to submit examples of such approaches to the FCGH Secretariat to feed into the database. This should increase uptake of these practices, strengthening accountability to the right to health and thus improving compliance with the FCGH. As part of an FCGH monitoring and evaluation process, states might even be required to report on measures that they are taking—including by making use of the best available evidence, including through the database—to adopt measures that will enhance accountability to the right to health from the community to national levels.

Leadership is essential. Right-to-health proponents can identify and nurture respected officials in government to chart the way. And they can advocate for government positions that are mandated to pursue the right to health, like Uganda's right-to-health desk, and for dynamic individuals to fill such positions.

Motivated policymakers will need the means to effectively implement the right to health. A growing set of health and human rights tools can support this capacity (see Table 1), and assure policymakers that FCGH mandates, such as right-to-health assessments, are feasible. The human rights community can create more advanced tools, such as further practical guidance to policymakers in specific health areas and

Table 1. Health and human rights tools

Tool	Description	FCGH Implementation
Health, human rights, and impact assessments		
Human Rights Impact Assessment for the Formation and Evaluation of Public Health Policies (Lawrence O. Gostin and Jonathan M. Mann, 1994) ²⁷	Provides questions to guide public health policies that may burden human rights	These tools will help implement an FCGH mandate on health and human rights assessments, including to incorporate the right to health in health strategies and interventions, and to ensure that policies and projects beyond the health sector that impact health are consistent with the right to health. Some of these tools address specific areas that health strategies should address, including the health workforce and reducing health sector discrimination. Many can be used proactively to design health strategies and policies and activities in other sectors that protect and promote the right to health. Civil society can use them to evaluate government implementation of the right to health. The first tool is slightly different, aimed at minimizing the possible burden of public health strategies on other human rights.
Health Rights of Women Assessment Instrument (Aim for Human Rights, 2010) ²⁸	Instrument to assess impact of policies on women's health rights and develop action plans to better realize women's health rights	
The Assessment of the Right to Health and Health Care at the Country Level: A People's Health Movement Guide (People's Health Movement, 2006) ²⁹	Guide to assess government implementation of right-to-health obligations and develop recommendations to address violations	
Health Impact Assessment (World Health Organization) ³⁰	Tools and guidance documents to determine how policies in different sectors will affect the public's health and the health of vulnerable groups	
Human Rights Impact Assessment Tools and Instruments (Human Rights Impact Resource Center) ³¹	Various tools to assess the impact of policies on human rights, including rights to health, food, and housing	
Incorporating the Right to Health into Health Workforce Plans: Key Considerations (Health Workforce Advocacy Initiative, 2009) ³²	Questions to guide policymakers and civil society on incorporating the right to health into health workforce plans and policies	
Ensuring Equality: A Guide to Addressing and Eliminating Stigma and Discrimination in the Health Sector (Physicians for Human Rights, 2011) ³³	Guide to a comprehensive approach to reduce stigma and discrimination in the health sector	
Enforcing the right to health		
Global Health and Human Rights Database (O'Neill Institute for National and Global Health Law at Georgetown University Law Center, World Health Organization, and Lawyers Collective, launching summer 2012) ³⁴	Database of more than 350 health and human rights cases and international instruments and national constitutions from around the world that enshrine health-related rights	An FCGH could encourage or require countries to contribute to this or a similar database, which could assist civil society and legal professionals in using litigation to enforce the right to health, and aid the judiciary in using effective approaches to adjudicate health rights claims, including by prescribing innovative remedies.
Monitoring the right to health		
Health Systems and the Right to Health: An Assessment of 194 Countries (Gunilla Backman, Paul Hunt, Rajat Khosla et al., 2008) ³⁵	Preliminary set of 72 health and human rights indicators	These indicators, including as they may be further refined, could inform countries in developing right to health-based health strategies, as an FCGH would require; contribute to monitoring implementation of the right to health; and assist in monitoring FCGH compliance.
Maternal Death Audit as a Tool Reducing Maternal Mortality (World Bank, 2011) ³⁶	Provides guidance on and a sample form for maternal death audits	This tool could assist countries in implementing a possible FCGH mandate to conduct maternal death audits.

right-to-health issues.

USING CREATIVE STRATEGIES TO ENHANCE NATIONAL RIGHT-TO-HEALTH LITIGATION

From increasing access to food and medicine to supporting tobacco prevention and control, constitutional provisions and court cases are contributing to healthier populations. AIDS advocates from South Africa and India to Latin America took to the courts to argue that human rights obligate government to provide AIDS medications—and they won.³⁷ In India, the right to food has resulted in cooked meals for millions of school children.³⁸ A regional human rights commission catalyzed the transformation of Paraguay's mental health system from institutionalization to community care.³⁹ In Colombia, where unsafe abortions are a leading cause of maternal death, the highest court demanded abortion legalization to protect women's health.⁴⁰ And an Indian court prohibited smoking in public places to safeguard the right to life.⁴¹

Yet even constitutional rights and successful litigation do not always lead to better health. Enforcing an individual's right to health without regard to the cumulative impact of individual cases risks unintended negative effects on equity. Courts may feel institutionally constrained from issuing bold orders, and without a watchful eye upon them, states may fail to implement court directives.

Three steps could take right-to-health litigation to the next level. First, courts could adapt and build upon the most progressive approaches. Where constitutions do not expressly guarantee the underlying determinants of health, courts can read them into the right to health or life. Courts could be open to claims of immediate enforceability of minimum core obligations.

They should constantly interrogate the policy and equity implications of their judgments and of government policies. As South Africa's Constitutional Court insisted in the landmark right-to-housing case *Government of the Republic of South Africa v. Grootboom*, to meet the constitutional standard of reasonableness, the government's housing plan would have to "provide relief for people who have no access to land, no roof over their heads, and who are living in intolerable conditions or crisis situations."⁴² Courts could institute a comparable test in all areas connect-

ed to health and its underlying determinants.

Pushing the boundaries of the right to health requires engaging some of the most doctrinally difficult challenges: What precisely are the minimum core obligations? What are the proper benchmarks for maximum available resources? What pace of progress does progressive realization require? With respect to the minimum core obligations requirement to ensure "essential primary care," courts could require a government strategy to achieve universal primary care.⁴³ Courts could assess whether the strategy is fully funded and adequately prioritizes reaching poor and other marginalized groups. Going a step further, courts could directly require countries to establish and define a benefit package to which everyone would be entitled.

Courts' role in establishing and passing judgment on minimum core obligations has been challenged from several directions. In *Grootboom*, the court doubted its own competence to establish such obligations. The South African Court has also sought a level of deference to the elected branches of government in evaluating the government's implementation of socioeconomic rights.⁴⁴ Meanwhile, experience elsewhere suggests that case-by-case challenges of often expensive health services not included in national health benefit packages risk diverting funds from other services that could better meet the needs of the whole population, including its poorer members. This is particularly true when limited access to courts means that the poorest members of the population are unlikely to be the litigants. However, new evidence from Brazil, challenging earlier findings, suggests that this case-to-case approach can be an important way for even very low-income individuals to secure needed medicines.⁴⁵

Courts might take a lesson from the Constitutional Court of Colombia in combining the clarity, accountability, and equity of a defined set of minimum health services for all with the inclusive, participatory processes that ensure democratic legitimacy, competence, and equity. In 2008, the Colombian court required the government to unify two health insurance schemes and to achieve the government's stated goal of universal insurance coverage by 2010. The unification process had "to be participatory, transparent, and evidence-based, and to include relevant indicators and benchmarks."⁴⁶ Rather than determining the benefits of the unified scheme itself, the court ordered the relevant health authority "to immediately

and on an annual basis comprehensively update the benefits included...through a process that included ‘direct and effective participation of the medical community and the users of the health system,’ in particular those who would be most affected by policy changes.”⁴⁷ Such benefits would be immediately enforceable, as would other health services needed to address threats to a person’s minimum level of subsistence that the person could not afford.⁴⁸ The court recognized resource limitations: the benefits “need not be infinite but can be circumscribed to cover the health needs and priorities determined by the competent authorities in light of the efficient use of scarce resources.”⁴⁹ The benefits plan had to be “designed to protect the right to health according to the needs of the population,” with limitations being “reasonable and proportionate.”⁵⁰

Universal health coverage could extend to underlying determinants of health. Courts could be deferential if these guaranteed minimums have been developed through an inclusive, participatory process, adhere to requirements of equity, are consistent with maximum resource availability requirements, are regularly reviewed and updated, and are well implemented.

Courts could demand specific, time-bound action, with experts and community members themselves developing the remedy, much as the Colombian court sought to put the nature of universal coverage in the democratic domain. The approach adopted by the Inter-American Court of Human Rights in *Xákmok Kásek Indigenous Community* could similarly serve as a model. The court held that the Paraguayan government had a duty to guarantee the right to life to community members who lacked basic services as they sought to reclaim traditional lands. The court required Paraguay to prepare a study, involving specialists and community perspectives, on obstacles to health care and other basic needs, including food, water, and sanitation. Paraguay was then obliged to adapt its services to the study’s conclusions.⁵¹ A participatory approach could be linked to substantive parameters encompassing areas including equity and resources to ensure a robust outcome.

Courts are most likely to adopt these approaches if judges and lawyers are well-versed in the right to health. Therefore, a second step to better realize the right to health through litigation is training for legal professionals on health and human rights, courts’ approaches in other jurisdictions, and the real-world

impact of their decisions (including on equity and implementation). A new health and human rights database opens up new possibilities for cross-border learning.⁵² Judges and lawyers could be exposed to innovative applications of socioeconomic rights, such as the South Africa Constitutional Court finding that these rights required an independent anti-corruption body.⁵³

The FCGH might require countries to periodically submit relevant cases to the treaty Secretariat to ensure that the database is comprehensive and current, maximizing its potential to aid litigants in protecting their rights and courts in adjudicating and offering the most effective remedies for violations. There is precedent for such a data-sharing requirement. The WHO Global Code of Practice on the International Recruitment of Health Personnel, for example, encourages countries to establish and maintain a database of laws and regulations relevant to health worker migration and recruitment, as well as their implementation. Countries are supposed to provide this information to WHO every three years.⁵⁴

An FCGH could establish one or several lead agencies, such as the WHO or the UN Office of the High Commissioner for Human Rights (OHCHR), or another process (involving such partners as the International Commission of Jurists), to establish a plan for this training. If such direct support for legal capacity-building within the judicial system stands out among human rights treaties, it builds upon other legal capacity-building stipulations in international law. The other health framework convention, the Framework Convention on Tobacco Control, stands as an important precedent, with its support for technical assistance to develop “a strong legislative foundation” for tobacco control measures.⁵⁵ Further afield, with the centrality of law enforcement to the treaty—though looking towards prosecutions by the state, rather than potentially against the state—the Convention against Corruption requires that countries, “to the extent necessary, initiate, develop or improve specific training programmes for its personnel responsible for preventing and combating corruption.” This is much as an FCGH might require training personnel responsible for enforcing the right to health. The Convention against Corruption encourages international technical assistance for this capacity-building, including training through international institutions.⁵⁶ In the realm of human rights itself, a resolution of the Pan American Health

Organization calls for educating legislative and judicial personnel on human rights standards.⁵⁷

Third, lawyers and civil society organizations need to view court victories as only part of a continuum of change. Compliance is a pervasive problem. In *Grootboom*, seen as a landmark victory for socio-economic rights, the seemingly victorious plaintiff, Irene Grootboom, died eight years after the judgment, “still homeless and penniless.”⁵⁸ Advocates for victorious parties in right-to-health cases must follow through to see that policies—and lives—really change.

Change is most likely if advocates combine litigation with a broader strategy. For example, in 2011 Ugandan health and human rights advocates initiated a case against the government to force action to reduce maternal mortality, asserting violations of the rights to life and health, and the rights of women. Civil society organizations have coordinated the litigation with a comprehensive advocacy strategy including petitions, civil society and public mobilization, and media pressure. Since the Centre for Health, Human Rights and Development initiated the case, more than 35 civil society organizations in Uganda have come together to form a coalition advocating for maternal health.⁵⁹

EMPOWERING CIVIL SOCIETY AND COMMUNITIES TO CLAIM THEIR RIGHT TO HEALTH

Pressure from civil society and the broader public can generate the political imperative to secure the right to health. Empowering communities to understand and claim their rights represents the third pillar of a health and human rights strategy. This pillar is constructed of public understanding, participation, accountability, and advocacy. It recognizes that more than a set of legal doctrines, human rights demand a fundamental redistribution of power from states to individuals, especially those who have traditionally held the least power.

Incorporating the right to health into laws, regulations, policies, and practices begins with establishing participatory and inclusive policy development processes that provide a privileged place for poor and marginalized communities. Public input and civil society organizations should inform health-related policies and identify areas where policy reform is required. Community involvement in implementing, monitoring, and evaluating policies must follow, so

that reforms are carried out effectively, respond to local priorities and realities, and reach those in greatest need. Mechanisms range from the national (e.g., national health assemblies and multi-sector health committees) to the local (e.g., village health committees), and from open processes that engage many people (e.g., regulatory notice comments procedures) to those engaging selected community and civil society representatives (e.g., community health boards).

In addressing community level accountability and offering health decision-making guidelines, an FCGH should insist that countries incorporate ways to ensure meaningful participation of marginalized and vulnerable populations and to emphasize their needs. A central aspect of an FCGH would be to establish standards of universal health coverage, for both health care and the underlying determinants of health. Countries could be required to follow inclusive, participatory approaches to translating these global guidelines into specific national standards and policies, and not rely solely on a technocratic approach (e.g., by setting the standards simply by determining most cost-effective interventions that would comply with the global guidelines; such evidence should have a role, but not an exclusive one).

People will be best equipped to pursue the right to health if they understand their rights. Civil society and the media can educate the populace. Journalists will themselves often need to be educated on, and sensitized to, health and human rights. Government institutions have an educational role. The Uganda Human Rights Commission’s health rights unit seeks to help “people realise what they are entitled to in the health units and empower them to demand...the services,” and offers legal aid to people whose health rights are violated.⁶⁰ Health workers can be a powerful force for the right to health, respecting it in their own practices, educating patients, and advocating locally and nationally. Their educational curricula should incorporate human rights, including the right to health. An FCGH could commit countries to incorporating human rights into training for all health workers and to establishing an agency—perhaps a governmental entity within the health ministry, or perhaps an empowered independent institution, such as a strong human rights commission—charged with facilitating implementing the right to health. This should encompass assisting people in claiming this right, including through education on the right to health, and ensuring that people can access legal recourse to remedy

violations. Such a requirement would be similar to, if more specific than, the duty in the Convention on the Rights of People with Disabilities to “maintain, strengthen, designate or establish...a framework, including one or more independent mechanisms...to promote, protect and monitor implementation of the present Convention.”⁶¹

Knowledge of the right to health alone, even combined with access to the legal system, is not enough. Civil society capacity-building is needed, including core and programmatic funding; fundraising, budgeting, management, and information technology skills; strategic planning; and training in advocacy strategies and tactics (e.g., budget monitoring and community scorecards). Capacity-building should be supplemented by capacity sharing, that is, facilitating connections among civil society organizations: developing health and human rights networks within countries and regions to share skills, experiences, and lessons, and to join forces in advocacy campaigns. The PAHO human rights resolution incorporates some of these capacity-building measures, namely human rights training for health workers and promoting dissemination of human rights information among civil society organizations.⁶²

It is critical that an FCGH support often beleaguered civil society organizations that seek to advance health and other human rights, but find their time consumed by fundraising as much as change-making. This support could be part of the proffered right-to-health capacity-building fund, or a distinct mechanism, and should encompass less formally organized community groups and networks, whether geographically centered or sharing other common characteristics (e.g., disease status, gender, or disability). Such a fund could overcome the potential ineffectiveness of good intentions not backed by resources, such as the pledge in the Rio Political Declaration on Social Determinants of Health to “empower the role of communities and strengthen civil society contribution to policy-making and implementation by adopting measures to enable their effective participation for the public interest in decision-making.”⁶³

With increased funding and support should also come measures to augment the accountability of civil society organizations, particularly to the people on whose behalf they work. This accountability could come through their constituents’ direct involvement and decision-making authority within the organiza-

tions, NGOs effectively and transparently evaluating their own activities, and regular channels of communication, input, and feedback. Meanwhile, when one or several civil society organizations represent broader civil society, those organizations need to accurately portray the positions and ideas of broader coalitions, report back on results, and gather feedback to contribute to a cycle of meaningful representation.

Health and human rights advocacy cannot be viewed apart from the broader human rights environment that will impact this advocacy, such as freedom of expression and assembly, the right to information, and the free operation of civil society organizations. Feeling their power and control over society threatened, a growing number of regimes have restricted NGOs’ ability to register and raise money, especially from foreign sources, and have limited the activities of internationally supported NGOs, including human rights advocacy.⁶⁴

The FCGH might require countries to review, rescind, and avoid future laws that could obstruct civil society right-to-health advocacy through the type of laws described above. An internationally financed civil society fund might help give some solace to—or more likely, remove a propaganda point from—governments that are skittish about the foreign influence of NGOs. It will provide funds that are clearly not linked to an agenda of any particular country—only to advancing the human rights and well-being of their people.

BRINGING THE RIGHT TO HEALTH TO THE CENTER OF GLOBAL GOVERNANCE FOR HEALTH

Much of this article is devoted to showing how an FCGH could help bring the right to health to the center of global governance for health. Here we expand on this concept to show how the international community could support effective health and human rights policies, progressive litigation, and empowered civil society and communities. These international efforts comprise the fourth pillar and build on ideas enunciated earlier, such as increasing funding for health and human rights organizations; providing technical support to build their capacity; and sharing lessons, facilitating international connections, and developing health and human rights tools and indicators that can be adapted locally.

Beyond this, countries must meet their own right-to-health obligations in the global arena. These include sustained, sufficient, and predictable development assistance, and protecting and advancing health and human rights in trade, investment, environment, and other spheres of international law.

An FCGH could codify and expand upon the foregoing responsibilities. It could establish an international financing framework that delineates funding obligations for each country, addressing both domestic and international responsibilities. It could establish new financing mechanisms, and unambiguously specify the priority to be given to health and human rights in other international legal regimes. An FCGH could go further by delineating what such priority would entail in these other areas, from affirmative requirements to address the health impact of climate change when developing adaptation measures, to protecting bilateral and regional trade agreements from provisions that could reduce access to medicine. It could require countries to assess the impact of macroeconomic policies on the right to health and avoid any that could undermine the right. The treaty could codify public health and human rights approaches to illicit drug use, which recognize addiction as a health condition requiring treatment and demand respect for the human rights of drug users. A treaty might also establish formal mechanisms of coordination among the WHO, the OHCHR, and key actors in other regimes, such as the World Trade Organization, World Bank, International Monetary Fund, International Labour Organization, UN Office on Drugs and Crime, and UN Environment Programme. Civil society and communities, as well as governments, would need to be assured of formative roles in any such mechanism. The WHO and OHCHR, with their health and human rights mandates, would be well-placed to lead such an entity.

The WHO should strengthen its own human rights capacity in line with its constitutional mandate.⁶⁵ The WHO should assume this leadership role, mainstreaming human rights throughout its programming, increasing its own human rights capacity in terms of staffing, funding, and organizational knowledge, and elevating the priority it gives human rights. It should lead and help coordinate international support for local health and human rights activities and advocate for other international legal regimes to incorporate health and human rights concerns.

Academia and think tanks can make human rights law itself more effective. By analyzing the fast-growing body of right-to-health law, examining how the right is being implemented, and offering new ideas, they can contribute to greater clarity of health and human rights law and to its progressive development. And they can increase understanding on the real-life impact of this law, factors that facilitate and impede its impact, and mechanisms to improve enforcement.

AN FCGH AND THE FOUR PILLARS OF HEALTH AND HUMAN RIGHTS

These four pillars—incorporating the right to health into national laws, using creative strategies to increase the impact of national right to health litigation, empowering communities to claim their rights, and bringing the right to health to the center of global governance for health—are integrally intertwined. Social movements spur legal and policy reform. Legal and policy change creates new opportunities for litigation. Elevating human rights in and integrating it throughout global governance for health will facilitate national progress, even as national processes, priorities, and experiences should inform global action.

An FCGH could help to simultaneously erect all four pillars. A successful FCGH will need to incorporate strong compliance mechanisms. These would begin with regular, public country reports on how they are implementing the treaty. Whether by requiring an inclusive process in developing these state reports, explicitly considering parallel civil society reports in evaluating state compliance, or both, the treaty should ensure that evaluation of compliance is not based simply on states' say-so.

Reporting cannot be the end of compliance strategies, however. While countries have considerable self-interest in improving the health of their own and the world's population, the treaty should also include creative incentives for compliance and sanctions for non-compliance.⁶⁶ For example, certain forms of international funding might be available or ensured only for countries that are meeting their own funding obligations. Non-compliance might open up the possibility of suspension from the possibility of serving on the WHO Executive Board or UN Human Rights Council. Given the lives on the line, targeted sanctions of the sort usually reserved for traditional national security concerns, such as freezing assets and travel bans on individuals, could be options in severe

cases. Any sanctions must themselves adhere to the highest human rights standards and not degrade the health and undermine the rights of the very people they are meant to help. Populations of countries whose governments are failing to meet their FCGH obligations should have a central role in determining what sanctions, if any, would be most appropriate and effective.

Critical to a successful FCGH will be a social movement that supports the treaty and the right to health more broadly. A powerful social movement, one that includes labor, environmental, and other broader concerns, can ensure that pressure for compliance comes from domestic as well as international sources. Indeed, a widely supported FCGH with clear standards could be a powerful tool for civil society advocacy in both the global South and North, even in countries that have not ratified the Convention themselves.

A comprehensive approach to advancing the right to health, backed by a global treaty, could prove a commanding counterweight to competing interests and political forces, advance effective policies and mechanisms for implementing the right to health, further clarify human rights law and attendant obligations, and enhance accountability and enforcement through community, national, and international actions.

Due regard to each pillar, drawing on and adding to innovative right-to-health approaches and capturing the synergies among the pillars, holds much promise for global health. With bold, systematic, and innovative actions, human rights stand to have a transformative impact in making global health better tomorrow than it is today.

We believe an FCGH could powerfully advance the right to health and close national and global health inequities. JALI envisions a treaty developed through a broadly inclusive “bottom-up” process. While hoping that our ideas contribute, we know that ultimately the most important input into an FCGH will come from the people whose health realities are worlds away from our own. The treaty must speak to the realities of slum dwellers who live near centers of power yet lack the most basic services, to farmers who find themselves and their children without proper nourishment, and to the orphans and widows, indigenous populations, sexual minorities, women, people with disabilities, and others who often suffer the ugliest

discrimination and most extreme poverty. It is their voices that JALI most hopes to hear and incorporate in guiding a process to develop an FCGH.⁶⁷

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